General

Guideline Title

Glaucoma referral and safe discharge. A national clinical guideline.

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Glaucoma referral and safe discharge. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2015 Mar. 38 p. (SIGN publication; no. 144). [72 references]

Guideline Status

This is the current release of the guideline.

Any amendments to the guideline will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

This guideline meets NGC's (2013) revised inclusion criteria.

Recommendations

Major Recommendations

The grades of recommendations (strong, conditional) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Primary-Care Examination and Assessment of Patients with Ocular Hypertension or Suspected Glaucoma

Measurement of Intraocular Pressure

For patients with ocular hypertension or suspected glaucoma a reliable baseline measure of intraocular pressure is required. A minimum of two intraocular pressure readings on a single occasion using the same tonometer is recommended. The type of tonometer and the time of measurement should be specified in any referral to secondary-eye-care services.

Measurement of Central Corneal Thickness

Central corneal thickness should be measured in patients with ocular hypertension or suspected glaucoma and reported alongside the measured intraocular pressure results when referring to secondary-eye-care services.

Assessment of Anterior Chamber Angle

Depending on practitioner's preference and clinical competence, either the Van Herick method or gonioscopy may be used to detect narrow anterior chamber angles in patients with ocular hypertension or suspected angle closure.

Optic Disc Assessment

For patients with suspected glaucoma the optic discs should be examined by slit-lamp biomicroscopy. The vertical optic disc diameter should be measured using the slit beam height. This should be corrected for the magnification of the condensing lens, and the disc categorised as small, medium or large.

The narrowest rim/disc ratio and disc size should be recorded and considered alongside additional indicators of glaucoma, such as optic disc nerve fibre layer haemorrhage and cup/disc ratio asymmetry, when assessing the need for referral to secondary-eye-care services.

The optic discs should be photographed and the images transmitted with the electronic referral letter.

Visual Field Assessment

For patients with ocular hypertension or suspected glaucoma, standard automated perimetry is recommended for visual field testing. Frequency doubling technology is also acceptable.

Monitoring At-Risk Groups

Patients with Ocular Hypertension

For patients with ocular hypertension, treated or untreated, a reliable baseline based on repeated measurement of intraocular pressure and perimetry should be established. Repeat glaucoma testing every two years is recommended.

Definitions

Levels of Evidence

1++: High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High-quality systematic reviews of case-control or cohort studies

High-quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Strength of Recommendation

Some recommendations can be made with more certainty than others. The wording used in the recommendations in the guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

The strength of a recommendation takes into account the quality (level) of the evidence. Although higher-quality evidence is more likely to be associated with strong recommendations than lower-quality evidence, a particular level of quality does not automatically lead to a particular strength of recommendation.

Other factors that are taken into account when forming recommendations include: relevance to the National Health Service (NHS) in Scotland; applicability of published evidence to the target population; consistency of the body of evidence, and the balance of benefits and harms of the options.

For 'strong' recommendations on interventions that 'should' be used, the guideline development group is confident that, for the vast majority of people, the intervention (or interventions) will do more good than harm.

For 'conditional' recommendations on interventions that should be 'considered', the guideline development group is confident that the intervention will do more good than harm for most patients. The choice of intervention is therefore more likely to vary depending on a person's values and preferences, and so the healthcare professional should spend more time discussing the options with the patient.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Glaucoma

Note: The guideline excludes treatment of ocular hypertension and glaucoma.

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Clinical Specialty

Family Practice

Geriatrics

Ophthalmology

Optometry

Intended Users

Advanced Practice Nurses

Health Care Providers

Hospitals

Nurses

Optometrists

Patients

Physician Assistants

Physicians

Guideline Objective(s)

- To provide recommendations based on current evidence for best practice in the primary-care assessment and referral of patients with suspected glaucoma of any subtype, from the community into secondary-eye care services and the safe discharge of patients from secondary-eye-care services back into the community
- To provide recommendations on the investigations required, the frequency of examinations and communication and notification of all the healthcare providers involved in the patient pathway
- To make recommendations on identifying which patients can be safely followed up in the community maximising the potential of the existing General Ophthalmic Services (GOS) arrangements and the electronic interface between community optometry and National Health Service (NHS) health boards through the Eyecare Integration Project

Target Population

Adult patients with suspected glaucoma

Interventions and Practices Considered

1. Baseline measurement of intraocular pressure
2. Measurement of central corneal thickness
3. Assessment of anterior chamber angle (Van Herick method or gonioscopy)
4. Optic disc assessment
5. Optic disc photography
6. Visual field assessment with standard automated perimetry
7. Monitoring of at-risk groups

Major Outcomes Considered

- Symptoms suggestive of glaucoma
- Clinical utility of diagnostic tools
- Sensitivity and specificity of diagnostic tests
- Risk of conversion to glaucoma
- Patient understanding of the monitoring and testing process
- Cost-effectiveness
- Effectiveness of monitoring frequency
- Risk of glaucoma diagnosis
- Progression of disease
- Waiting times
- Patient satisfaction
- Healthcare professional satisfaction

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Literature Review

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology (see

SIGN 50 [see the "Availability of Companion Documents" field]). A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Evidence and Information Scientist. Databases searched include Medline and the Cochrane Library. The year range covered was 2007–2014. The main searches were supplemented by material identified by individual members of the development group. Each of the selected papers was evaluated by two members of the group using standard SIGN methodological checklists before conclusions were considered as evidence.

Please refer to the search strategy document (see the "Availability of Companion Documents" field) for further information on the search strategy, including search terms used.

Number of Source Documents

See the search strategy document (see the "Availability of Companion Documents" field) for results of the literature search process.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++: High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High-quality systematic reviews of case-control or cohort studies

High-quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

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2-: Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Evaluating the Literature

Once studies have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity.

The methodological assessment is based on a number of criteria that focus on those aspects of the study design that research has shown to have a significant effect on the risk of bias in the results reported and conclusions drawn. These criteria differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. The Scottish Intercollegiate Guidelines Network (SIGN) checklist for systematic reviews has been updated based on the AMSTAR (A Measurement Tool to Assess Systematic Reviews) tool, while that for randomised controlled trials (RCTs) is based on an internal project carried out in 1997. Checklists for observational studies are based on the

MERGE (Method for Evaluating Research and Guideline Evidence) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. The checklist for diagnostic accuracy studies is based on the QUADAS (Quality Assessment of Diagnostic Accuracy Studies) programme.

These checklists were subjected to detailed evaluation and adaptation to meet SIGN's requirements for a balance between methodological rigour and practicality of use. Copies of these checklists and accompanying notes on their use are available on the SIGN Web site .

The assessment process inevitably involves a degree of subjectivity. The extent to which a study meets a particular criterion, for example an acceptable level of loss to follow-up and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context and inevitably the judgment of the individual reviewers.

The methodology of studies selected for full consideration will be appraised by at least two people with experience in carrying out such appraisals. The subjective nature of critical appraisal makes double checking essential to minimise the chance of bias and to ensure consistency. Where reviewers cannot agree on the overall quality of a study the Programme Manager will arbitrate before a study goes forward for inclusion in the evidence base. This only applies to studies being actively considered as evidence. There is no need to seek agreement for studies that are not to be included. Any study that has not been included in this process cannot be used as evidence to support a recommendation in the guideline.

Considering the Quality of Evidence

SIGN is committed to following the principles of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology which complies with the standards covered in Section 5.1 of SIGN 50 (see the "Availability of Companion Documents" field). The process for assessing the overall quality of evidence using GRADE, is described in the Journal of Clinical Epidemiology (JCE) series on GRADE.

From this point in the process the guideline development group is looking at a body of evidence for each question; the collection of studies that help answer the question. This raises a number of issues beyond the methodological quality of the individual studies.

The evaluation of a body of evidence should be completed before deciding what to recommend in the guideline. The focus here is on the quality of the available evidence, not what conclusions may be drawn from it.

The evidence identified in a systematic review of the published literature is first summarised in an evidence table. An example of a completed evidence table records appears in Figure 5-1 of SIGN 50. In summary, at the end of this stage of the process, the guideline development group will have agreed on the overall quality of the evidence for all critical outcomes for the key questions being addressed.

Additional details can be found in SIGN 50.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Evidence to Recommendation

It is worth keeping in mind at all times that fundamental to the approach to guideline development is the issue of transparency. Different guideline developers will allocate greater or fewer resources to developing their guidelines, and the detail of the work they do will vary accordingly. The important point in all that follows is to be clear about what was actually done at each stage of the process. Justifications can be provided if thought necessary, but the key point is to produce a structured summary of the complete process that reviewers or guideline users can check when they are considering implementation of the guideline.

Is This Question a Priority?

Given that a question has survived through the processes of topic selection and key question setting, it might be taken as read that it is a priority. The intention here, however, is to indicate why the question is being addressed.

- What risks will be reduced?
- To what extent is there a need to improve on current treatments?
- How many patients are likely to be affected?

- Could improvement in this condition reduce the risk/impact of common comorbid conditions?

These are some of the types of issue to be addressed here.

Members of the guideline development group have a key role to play as they will be aware of the main issues that make a question important, as well as some of the key information that will illustrate that importance. Their knowledge may be supplemented by evidence from official data, published sources, or research studies.

How Sure Is the Guideline Development Group That Any Given Option Will Work?

At this point the guideline development group relies on the summarised evidence produced at the previous stage in the process. The factors described in the following sections are then considered in part B of the considered judgment form (see Figure 5-2 of SIGN 50 [see the "Availability of Companion Documents" field]) to allow recommendations to be formed from the evidence.

Ideally this table can be taken from a summary of findings (SoF), but this is unlikely to be available in every case. For those key questions where an SoF is not available, an alternative short format presenting non-pooled results (for example, an evidence table) will suffice. The guideline development group should focus on (for each outcome):

- Outcome
- Impact
- Number of studies
- Quality/certainty of the body of evidence

Balancing Benefits and Harms

Fundamental to making any recommendation is the need to ensure that any benefit to the patient outweighs, preferably by a substantial margin, any risks or harms associated with the treatment.

In order to make such judgments, the guideline development group has to have a clear understanding of how substantial the expected benefits of an intervention are likely to be in practice. They also need to consider how substantial the downsides are. These may range from physical side effects to an increased risk of developing additional health problems.

The evidence supporting benefits will often come from stronger study designs than that supporting harms. This makes judgments more difficult, but it is nonetheless essential to explicitly consider the size of effect for both sides of the balance. A detailed presentation of the evidence from a summary of findings or similar table is essential when making such decisions.

Once the size of all effects has been established, a judgment must be made as to whether the benefits outweigh the harms. This is not just a clinical judgment but must take into account patient values (see below) if a realistic assessment is to be achieved.

How Do Patients Value the Different Outcomes?

For a recommendation to be implemented effectively, it is important that the outcomes are sufficiently valued by patients for them to be willing to adhere to the treatment. The science of assessing patient values and preferences, however, remains largely undeveloped. When developing guideline recommendations, the focus should be on questions where the application of values is likely to affect outcomes and should rely on practical and achievable methods.

Equity

Under the Equality Act 2010 all public bodies in Scotland are required to take into account the needs of equality groups. This applies to all guidelines and other publications produced by the Scottish Intercollegiate Guidelines Network (SIGN).

Making Recommendations

Balancing all the issues described above is a matter of considerable complexity, and presents a challenge to any guideline group. High quality evidence from well conducted studies should lead to a strong recommendation, but relating the trial populations to the target population of a guideline and taking into account issues of cost and patient acceptability may lead to a recommendation that is much weaker than first thought. Equally, there will be circumstances where the evidence is flawed but there are few or no downsides to treatment and the clinical importance of the topic is such that a strong recommendation is justifiable.

It is not possible for SIGN or any other guideline organisation to advise or direct a guideline group as to the conclusions they should reach. All that can be asked is that the group considers all the issues and uses a transparent process to reach their conclusion.

Particularly where considerations of equity or comorbidity are involved, the guideline development group may have to make more than one recommendation; one for each subgroup discussed.

In all situations, however, the overall judgment of the guideline development group can only lead to one of the five possible conclusions shown in the table below, each related to a particular form of recommendation.

Forms of Recommendation

Judgment	Recommendation
Undesirable consequences clearly outweigh desirable consequences	Strong recommendation against
Undesirable consequences probably outweigh desirable consequences	Conditional recommendation against
Balance between desirable and undesirable consequences is closely balanced or uncertain	Recommendation for research and possibly conditional recommendation for use restricted to trials
Desirable consequences probably outweigh undesirable consequences	Conditional recommendation for
Desirable consequences clearly outweigh undesirable consequences	Strong recommendation for

Whatever the conclusion, the published guideline and supporting documentation should contain a justification for the recommendation highlighting the supporting evidence and the factors that have been taken into account when arriving at a conclusion. Where decisions are particularly complex, such a justification may be quite lengthy. In these cases the full justification can be included in supporting material with a shortened version included in the published guideline.

Additional details about SIGN's process for formulating guideline recommendations is provided in Section 6 of "SIGN 50: A Guideline Developers' Handbook" (see the "Availability of Companion Documents" field).

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

Some recommendations can be made with more certainty than others. The wording used in the recommendations in the guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

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Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Consultation and Peer Review

National Open Meeting

A national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group presents its draft recommendations for the first time. The national open meeting for this guideline was held on 20 March 2014 and was attended by 131 representatives of all the key specialties relevant to the guideline. The draft guideline was also available on the SIGN Web site for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

Specialist Reviewers Invited to Comment on This Draft

This guideline was also reviewed in draft form by independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. The guideline group addresses every comment made by an external reviewer, and must justify any disagreement with the reviewers' comments. All expert referees made declarations of interest and further details of these are available on request from the SIGN Executive.

SIGN Editorial Group

As a final quality control check, the guideline is reviewed by an editorial group comprising the relevant specialty representatives on SIGN Council to ensure that the specialist reviewers' comments have been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. All members of SIGN Council make yearly declarations of interest. A register of interests is available on the SIGN Council Membership page of the SIGN Web site .

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Early identification and referral of patients with ophthalmic pathology and prompt secondary-care response facilitates timely management with the aim of limiting visual disability.

Potential Harms

False-positive glaucoma referrals

Qualifying Statements

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.
- Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed out with the marketing authorisation (MA) also known as product license. This is known as 'off label' use.
  Medicines may be prescribed off label in the following circumstances:

  - For an indication not specified within the marketing authorization
  - For administration via a different route
  - For administration of a different dose
  - For a different patient population

  An unlicensed medicine is a medicine which does not have MA for medicinal use in humans.

  Generally the off label use of medicines becomes necessary if the clinical need cannot be met by licensed medicines within the marketing authorisation. Such use should be supported by appropriate evidence and experience.

  "Prescribing medicines outside the conditions of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability."

  The General Medical Council (GMC) recommends that when prescribing a medicine off-label, doctors should:

  - Be satisfied that such use would better serve the patient's needs than an authorised alternative (if one exists)
  - Be satisfied that there is sufficient evidence/experience of using the medicines to show its safety and efficacy, seeking the necessary information from appropriate sources
  - Record in the patient's clinical notes the medicine prescribed and, when not following common practice, the reasons for the choice
  - Take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring the effects of the medicine

  Non-medical prescribers should ensure that they are familiar with the legislative framework and their own professional prescribing standards.

  Prior to any prescribing, the licensing status of a medication should be checked in summary of product characteristic (www.medicines.org.uk). The prescriber must be competent, operate within the professional code of ethics of their statutory bodies and the prescribing practices of their employers.

Implementation of the Guideline

Description of Implementation Strategy

Implementation Strategy

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) board and is an essential part of clinical governance. Mechanisms should be in place to review care provided against the guideline recommendations. The reasons for any differences should be assessed and addressed where appropriate. Local arrangements should then be made to implement the national guideline in individual hospitals, units and practices.

Refer to Section 9 in the original guideline for information on resource implications associated with implementing the key clinical recommendations and advice on audit as a tool to aid implementation.

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Mobile Device Resources

Patient Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Glaucoma referral and safe discharge. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2015 Mar. 38 p. (SIGN publication; no. 144). [72 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2015 Mar

Guideline Developer(s)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

Source(s) of Funding

Scottish Executive Health Department

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group: Dr Roshini Sanders (*Chair*), Consultant in Ophthalmology, Queen Margaret Hospital, Dunfermline; Dr Pankaj Agarwal, Consultant in Ophthalmology (Glaucoma Specialist), Princess Alexandra Eye Pavilion, Edinburgh; Ms Gillian Bruce, Optometrist, Edinburgh; Dr Jennifer Burr, Reader, University of St Andrews; Mr Peter Carson, Optometrist, Optometry Scotland, Glasgow; Mr Ian Clement, Lay Representative, Edinburgh; Mrs Lisa Cowan, Senior Postgraduate Optometry Tutor, NHS Education for Scotland, Glasgow; Dr Alastair Glennie, General Practitioner, Kemnay; Mr John Hughes, Development Manager (Scotland), International Glaucoma Association; Dr Manjula Kumarasamy, Consultant in Ophthalmology (Glaucoma Specialist), Aberdeen Royal Infirmary; Mrs Lorna McKay, Highly Specialist Orthoptist, Southern General Hospital, Glasgow; Ms Shirley Miller, Ophthalmic Glaucoma Nurse Practitioner, Queen Margaret Hospital, Dunfermline; Dr Donald Montgomery, Consultant in Ophthalmology (Glaucoma Specialist), Glasgow Royal Infirmary; Mr Frank Munro, Chair, NHS Education for Scotland Optometric Advisory Committee; Mr Hal Rollason, Optometrist, College of Optometrists, London; Dr Carolyn Sleith, Evidence and Information Scientist, SIGN; Dr Andreas Syrogiannis, Specialty Registrar in Ophthalmology, Ninewells Hospital, Dundee; Dr Lorna Thompson, Programme Manager, SIGN

Financial Disclosures/Conflicts of Interest

All members of the guideline development group made declarations of interest. A register of interests is available in the supporting material section for this guideline at www.sign.ac.uk.

Guideline Status

This is the current release of the guideline.

Any amendments to the guideline will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

This guideline meets NGC's (2013) revised inclusion criteria.

Guideline Availability

Available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

Availability of Companion Documents

The following are available:

- Glaucoma referral and safe discharge. Quick reference guide. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2015 Mar. 2 p. Available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.
- Glaucoma referral and safe discharge. Search strategies. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2015 Mar. 4 p. Available from the SIGN Web site.
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2014 Oct. 62 p. (SIGN publication; no. 50). Available from the SIGN Web site.

In addition, Section 9 in the original guideline document contains key points to audit. Annexes 3-5 contain a Spaeth's disc damage likelihood scale and both a NHSScotland glaucoma referral and discharge form.

Executive summaries of SIGN guidelines are available for mobile devices through the guidelines app on the SIGN Web site

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Patient Resources

The following is available:

- Glaucoma referral and safe discharge. A booklet for patients, their families and carers. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2015. 24 p. Available in regular and large print from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on December 1, 2015. The information was not verified by the guideline developer.

Copyright Statement

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